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The Role and Importance of the 'D' in PTSD

Michael P. Fisher and Terry L. Schell

In December 2012, the American Psychiatric Association (APA) board of trustees voted on changes to the new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Among the decisions was one to retain the word "disorder" in the term "posttraumatic stress disorder" (PTSD). U.S. Army leadership initially requested the change in terminology, stating that the word "disorder" is stigmatizing and that removing it would encourage more individuals suffering from symptoms to access care. Although the APA has issued its ruling, the term "posttraumatic stress" (PTS) is being used informally by some individuals within military communities. It is unclear whether informal use of the term will continue, or whether military leaders will continue to advocate future changes to the DSM. Our intent is to further the discussion regarding the removal or revision of the term "disorder." We explore the rationales for not changing the diagnostic terminology, and to the extent possible, anticipate what the effects of widespread informal use of new terminology might be.

Post-traumatic stress disorder (PTSD) among U.S. military service members has emerged as an important policy issue. Prevalence estimates of PTSD among those returning from service in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn range from 5 to 20 percent, although the most representative studies find the prevalence of PTSD to be 10 to 14 percent among all of those previously deployed (Ramchand, Schell, et al., 2010).

In response to high rates of PTSD among deployed U.S. military service members, a myriad of programs and initiatives to address PTSD and other psychological health issues have been developed by practitioners, health services professionals, and researchers. The Department of Defense (DoD) alone sponsors or funds more than 200 programs that address psychological health or traumatic brain injury (TBI) across the prevention, identification, and treatment continuum (Weinick, Beckjord, et al., 2011).

Nearly half of these programs have some component that specifically addresses PTSD among military service members. DoD also provides care for PTSD through its military treatment facilities and its health care program, TRICARE. The Department of Veterans Affairs (VA), likewise, maintains a network of

Key Issues

- After considering the matter, the APA opted not to change the name of posttraumatic stress disorder (PTSD) despite a request by senior U.S. Army leadership.
- The Army's reasoning was that the term "disorder" is stigmatizing, and that removing or replacing it—for example, with the term "injury"—would encourage more U.S. military service members suffering from symptoms to access care.
- Some individuals within military communities are already using the term "posttraumatic stress" (PTS) informally, although the impact of this use—on mental health stigma or otherwise—is unclear.
- Few studies specifically demonstrate stigmatization among U.S. military service members with PTSD, and no known studies have shown that PTSD-related social stigmas reduce the utilization of treatment.
- Psychiatric diagnoses are used within institutions such as the U.S. military in ways that may adversely affect how a diagnosed individual is treated—for example, when determining eligibility for security clearances or fitness for deployment.
- Without changing the broader institutional factors that result in discrimination against those with the PTSD label, modifying that label seems unlikely to result in a significant increase in individuals willing to be diagnosed or treated.

Veterans Affairs medical centers and community-based outpatient clinics, of which 96 percent and 75 percent, respectively, provide specialized PTSD services (Watkins and Pincus, 2011).

With the APA deliberating on the content of its fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), senior U.S. Army leadership seized its chance to seek changes to the labeling of PTSD (Sagalyn, 2011a; Sagalyn, 2011b; Jaffe, 2012). The initial request was sent by then-Army Vice Chief of Staff General Peter Chiarelli to the APA's president

What Is PTSD?

PTSD is classified as a trauma- and stressor-related disorder and is now defined by criteria listed in the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, the DSM-5. The diagnostic criteria for PTSD include past exposure to a traumatic event involving actual or threatened death, serious injury, or sexual violence; intrusion symptoms such as distressing memories or dreams; persistent avoidance of stimuli associated with the traumatic event; negative alterations in cognitions and mood; and marked alterations in arousal and reactivity (APA, 2013). To constitute a diagnosis, symptoms must persist for one month following the trauma, cause significant functional impairment, and not be attributable to the physiological effects of a substance or another medical condition.

change in terminology, we first provide an overview of the DSM and the functions it serves, followed by a brief history of PTSD. We then highlight the intended functions of the PTSD diagnosis, which include interpreting, categorizing, and measuring the condition,¹ as well as facilitating treatment, treatment financing, and disability compensation. We also address other, possibly unintended, consequences of the PTSD diagnosis across a wide range of organizations and institutions and in the broader culture. These include legitimization of the condition, stigmatization of those with the condition, and discrimination against those with the condition. We conclude by summarizing the key points discussed in this paper and by offering our perspective, informed by the literature, on the possible implications of removing or replacing the term "disorder" in PTSD.

An Overview of the DSM and Psychiatric Classification

The APA-published DSM details the diagnostic criteria for the full range of recognized mental disorders. The first edition was published in 1952, and several new editions and revisions have since been released, including the fifth edition published in 2013. In the current published edition, a mental disorder is defined as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" and is "usually associated with significant distress or disability in social, occupational, or other important activities" (APA, 2013). An "expectable or culturally approved response to a common stressor or loss, such as the death of a loved one" would not be considered a mental disorder, nor would "socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society . . . unless the deviance or conflict results from a dysfunction in the individual, as described above" (APA, 2013).

A number of criteria are applied to a condition to ensure that it is appropriate for classification as a disorder in the DSM. These include a condition's clinical utility, reliability, descriptive validity, and psychometric performance characteristics (APA, 2013; APA, 2000; see also Robins and Guze, 1970). While these systematic principles are applied when considering whether to include a condition in the DSM, the process is not considered infallible, nor is the manual meant to represent the full range of possible conditions for which an individual may be treated (APA, 2013). Instead, the material contained within the DSM is considered to be a consensus of the evolving knowledge in the field. Disorders are used in the DSM to signify psychiatric diagnoses, generally. However, not all diagnostic categories within the DSM explicitly contain the term "disorder" in their titles. For example, "major depressive disorder" contains the term, while disorders such as schizophrenia do not.

Psychiatric diagnoses defined by the DSM are intended to serve several functions pertaining to treatment, research, and

at that time, Dr. John Oldham. It called for dropping the term "disorder" from the diagnostic label. The request represented what appears to be a more widespread concern within military communities—as well as for some who advocate on behalf of or provide treatment to traumatized or victimized individuals—that the term "disorder" is stigmatizing and that removing it would encourage more individuals suffering from symptoms to access care (PTSI injury endorsements web page, 2012; Sagalyn, 2011a; Sagalyn, 2011b; Jaffe, 2012).

In December 2011, the APA stated that it was open to discussion and would consider modifications to the DSM-5 terminology with this concern in mind (Sagalyn, 2011b; Jaffe, 2012). Specifically, the president of the APA indicated the possibility of adding a diagnostic subcategory of PTSD such as "*combat posttraumatic injury*," or changing the name of the diagnosis to "*posttraumatic stress injury*." In May 2012, the APA convened a panel discussion that focused on the topic. In late 2012, however, the APA's board of trustees eventually decided not to alter the term, omitting it from the proposed changes to DSM-5. Yet, while the APA's board of trustees deliberated changing the diagnostic terminology, military leaders and others increasingly used their own language to refer to PTSD. The term "*posttraumatic stress*" (PTS) is now being used by some individuals to refer to a range of posttraumatic stress responses, both those that meet the clinical threshold for PTSD and those that do not.

Although the APA's board of trustees decided not to alter diagnostic terminology, informal use of the term "*posttraumatic stress*" may continue, and the possibility of a future change remains, as military leaders may continue to press their case. In this paper, we review the historical, sociological, and clinical literature on the diagnosis of psychiatric disorders with a focus on PTSD. We restrict our attention in large part to peer-reviewed journal articles and books. In our effort to explore the effects of a

education. These include guiding clinical practice (e.g., classifying individuals into groups that might usefully direct their treatment), facilitating research and improving communication among clinicians and researchers, improving the collection of clinical information and communication of public health statistics, and providing a tool for teaching psychopathology (APA, 2013). As noted in the DSM-5's "cautionary statement for forensic use," the classification system is designed to meet the needs of the mental health treatment, research, and educational communities, and therefore the classifications may not be useful for other purposes. Notably, they do not correspond to legal categories related to culpability or dangerousness, nor are they designed to provide information about the capabilities of individuals performing specific tasks, including work-related tasks.

The World Health Organization (WHO) has developed international classification standards to categorize and code various types of disease, disorder, or injury. These standards include the International Classification of Disease (ICD),² the International Classification of Functioning, Disability and Health (ICF), and the International Classification of External Causes of Injury (ICECI). WHO has also developed "derived classifications," which are based on information in the ICD and ICF that has been augmented, rearranged, or reaggregated (WHO, 2012a). Derived classifications include the ICD-10 for Mental and Behavioral Disorders Clinical Descriptions and Diagnostic Guidelines and the ICD-10 for Mental and Behavioral Disorders Diagnostic Criteria for Research (Centers for Medicare and Medicaid Services, 2012). WHO's classification standards were developed in conjunction, and are closely aligned, with the DSM's categories for classifying mental disorders (APA, 2013). These standards serve as the official coding system for psychiatric disorders and diseases in the United States and several other countries. Diagnostic codes label disorders and diseases alphanumerically and are used for a wide range of epidemiological, health management, and clinical purposes. These include monitoring the incidence and prevalence of disease, analyzing the health situations of populations, classifying disease on health and vital records, and, in many instances, determining financial reimbursement for treatment (WHO, 2012b; WHO, 2010).

WHO's classification manuals also offer definitions of terms such as "disorder" and "injury." WHO echoes the APA in defining a mental disorder as "the existence of a clinically recognizable set of symptoms or behavior associated in most cases with distress and with interference with personal functions," while specifying that "social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here" (WHO, 1992). WHO defines an injury as "a (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance" (WHO, 2004). According to the sum of the definitions of "mental disorder" offered by the APA and WHO and the definition of "injury" offered by WHO, both

disorders and injuries may involve a behavioral, psychological, or biological reaction, but the term "injury" is reserved for those instances when an external physical force is the direct cause of the reaction.

A Brief History of PTSD

Many societies have recognized, through the use of various labels, that some individuals show a range of problems after exposure to traumatic events—including, but not limited to, trauma encountered during war. Terms used in the United States prior to "PTSD" include "soldier's heart" during the Civil War era, "railway spine" during the late 19th century, "shell shock" and "war neuroses" during the World War I era, and "combat fatigue" during the World War II era. A set of problematic symptoms, labeled "gross stress reaction," was recognized in the first edition of the DSM published in 1952 but was absent from the second, the DSM-II, published in 1968. As American service members returned from Vietnam, they exhibited problems stemming from exposure to traumatic events, which were recognized informally as "post-Vietnam syndrome" (Scott, 1990, 2004; Young, 1995; Dean, 1997; Shepard, 2001; Finley, 2011). In 1980, the APA incorporated the PTSD diagnosis into the DSM-III to classify responses to traumatic events that met a defined set of criteria (APA, 1980).

Formal recognition of PTSD resulted in part from years of advocacy and collaboration among psychiatrists and several groups representing victimized or traumatized individuals, including groups representing Vietnam veterans (Scott, 1990; Scott, 2004). In 1977, as plans were under way to revise and release the DSM-III, a group of mental health professionals who studied the psychological impacts of war trauma collaborated with veterans' advocates to form the Vietnam Veterans Working Group. The group mobilized the support of psychiatrists researching the psychological impacts of war and other types of trauma (Bloom, 2000), and proposed adding the diagnostic categories that would soon be labeled PTSD to the APA's Committee on Reactive Disorders, the collective body tasked with reporting to the DSM-III task force on issues of posttraumatic stress.

When the diagnostic entry was first proposed, the working group labeled it "catastrophic stress disorder" and suggested that a subcategory termed "post-combat stress reaction" accompany the diagnosis (Shatan, Smith, and Haley, 1976; see also Scott, 1990; Scott, 2004). The Committee on Reactive Disorders supported the recommendation with two changes. First, the new

Formal recognition of PTSD resulted in part from years of advocacy and collaboration among psychiatrists and several groups representing victimized or traumatized individuals.

diagnostic label was to be “*posttraumatic stress disorder*.” Second, the combat-specific subcategory would not be present, since there was little evidence that trauma from combat produces a significantly different set of clinical symptoms or impairments than severe noncombat trauma, such as rape or assault.³ Therefore, the newly formed PTSD diagnosis made no distinction between trauma experienced in combat and trauma experienced in other situations, such as personal assaults or natural disasters.

PTSD was added to the DSM-III in part to recognize the suffering of traumatized individuals, including Vietnam veterans, and to provide a channel for obtaining treatment (Scott, 1990, 2004; Young, 1995; Finley, 2011). At the same time that the APA was codifying the PTSD diagnosis, Congress was also recognizing the mental health needs of Vietnam veterans. In 1979, President Jimmy Carter signed Public Law 96-22, which established Vet Centers to provide “readjustment” counseling to Vietnam veterans (Young, 1995; Shepard, 2001; Scott, 2004). Although not created to address PTSD explicitly, these community-based Vet Centers offered counseling for a range of mental health issues, including the set of symptoms that was being labeled as PTSD in the DSM-III. The PTSD diagnosis also expanded treatment options for diagnosed individuals beyond Vet Centers, facilitating greater access to mental health treatment in other VA facilities and in private health systems.

The formal recognition of PTSD was also an attempt to distinguish the phenomenon from existing mental disorders (e.g., depression) that share several symptoms, but which typically have a different etiology and time-course, and to recognize this set of symptoms as a condition to be treated, rather than as cowardice or malingering (Scott, 1990; Scott, 2004; see also Jutel, 2009; Mezey and Robbins, 2001). As with all other DSM disorders, PTSD is used to differentiate normal functioning from a type of impaired functioning that might benefit from treatments that may be available. For instance, while many of the symptoms of PTSD may be considered normal or healthy during, or shortly after, a traumatic event, the PTSD diagnosis specifies that the symptoms must be present beyond one month following a traumatic event. More specifically, PTSD is defined by the persistence of these symptoms after the source of traumatic stress is gone and by the failure of the impairing symptoms to spontaneously resolve themselves. Since its incorporation in the DSM-III, the PTSD diagnosis was changed slightly in the subsequent editions of the manual, the DSM-IV and DSM-IV-TR. Notably, the original PTSD diagnosis did not require that individuals respond to a traumatic event with fear, helplessness, or horror; this criterion was added to the DSM-IV.

When the APA published the DSM-IV in 1994, it included a new diagnostic category termed Acute Stress Disorder (ASD) to categorize individuals suffering from problems stemming from exposure to a traumatic event for more than two days but less than four weeks after the event (APA, 1994). A primary function of defining ASD was to facilitate the early identification of individuals who would be unlikely to recover spontaneously

after traumatic events (Cahill and Pontoski, 2005). It was hoped that this classification would lead to earlier treatment for those who suffered significant impairment and were at high risk for developing PTSD (Cahill and Pontoski, 2005). The diagnostic criteria for ASD are similar to those for PTSD but feature one fundamental difference: ASD is diagnosed within the first month following a traumatic event.

The DSM-5, released in May 2013, includes several changes to the PTSD and ASD diagnostic criteria.

- The changes to the PTSD criteria include removal of the requirement that an individual respond to the traumatic event with fear, helplessness, or horror; more explicit requirements about how an individual must have experienced a traumatic event; the separation of the avoidance and numbing “cluster,” or set of similar symptoms, into two clusters (avoidance and negative alterations in cognitions and mood); the addition of two symptoms (persistent and distorted blame of self or others and persistent negative emotional state) to the negative alterations in cognitions and mood cluster; the addition of one symptom (reckless or destructive behavior) to the alterations in arousal and reactivity cluster; the revision of various symptoms to clarify symptom expression; and the addition of preschool and dissociative “subtypes,” or homogeneous subclassifications of the disorder which may have different etiologies (APA, 2013).
- The changes to the ASD criteria include removal of the requirement that an individual respond to the traumatic event with fear, helplessness, or horror; and the collapsing of several symptoms into a single cluster, which encompasses five types of symptoms: intrusion, negative mood, dissociation, avoidance, and arousal (APA, 2012). The newly expanded cluster describes a more varied acute stress response that does not require the presence of dissociative symptoms, as did the previous edition of the DSM.

The Intended Functions of the PTSD Diagnosis

The diagnosis of a mental health condition such as PTSD serves several purposes intended by the mental health treatment, research, and educational communities. These include interpreting, categorizing, and measuring the condition as well as facilitating treatment, treatment financing, and disability compensation for the condition. We discuss each of these topics below. In later sections, we explore other, possibly unintended, consequences of classifying disorders in an effort to identify the full range of implications of the PTSD diagnosis.

Interpreting, Categorizing, and Measuring the Condition

The disorder classification system of the DSM provides a common language for use by the mental health treatment, research, and educational communities and has been widely adopted as the defining nomenclature in the field. This common language facilitates communication between clinicians and researchers, clinicians who collaborate to care for patients, clinicians and the

organizations that pay for treatment, and clinicians and their patients (APA, 2013). The DSM categories also prompt the development of standardized tools such as diagnostic questionnaires and psychometric devices. Further, diagnostic categories, which are a product of research evidence supporting their inclusion in the DSM, spur the further development and distinct boundaries of a research base and allow for stable comparisons of sets of symptoms or behaviors over time and across populations. These interrelated activities have not occurred historically in examining problems stemming from exposure to traumatic events (Young, 1995; Dean, 1997).

Facilitating Treatment, Treatment Financing, and Disability Compensation

Another function of diagnosis is to facilitate treatment of the diagnosed condition so as to minimize impairment and suffering (Mezey and Robbins, 2001; Dumit, 2006; Jutel, 2009; Jutel, 2011). Identifying a set of symptoms or behaviors as a disorder effectively communicates that it is unhealthy (i.e., distressing, functionally impairing, or associated with a significant increase in suffering) and that individuals who exhibit those symptoms or behaviors may benefit from evaluation and treatment. A diagnosis often communicates to clinicians, insurance companies, and health systems that individuals with those symptoms may be eligible to have their financial obligations for treatment covered (contingent upon other factors such as whether the treatment is medically necessary) (Dumit, 2006; Jutel, 2009). Moreover, a diagnosis communicates to patients that a sometimes diverse and seemingly unrelated set of symptoms (e.g., emotional numbing and exaggerated startle response) may be linked and that treatment may be available to minimize those unpleasant symptoms or mitigate their impact.

Prior to the inclusion of PTSD in the DSM-III, war veterans encountered substantial difficulty obtaining treatment for problems stemming from exposure to traumatic events. Gross stress reaction, listed in the first edition of the DSM, did not capture delayed or chronic conditions (Scott, 2004), and, as stated above, the diagnosis was not included in the DSM-II. Not surprisingly, mental health clinicians in the VA during the 1970s noted a “lack of fit” between veterans’ symptoms and the diagnoses in the DSM-II, and in this respect, the DSM-II functioned as a substantial barrier to mental health treatment for Vietnam-era veterans (Scott, 2004; see also Shepard, 2001).

Formally identifying a set of symptoms or behaviors as a disorder also plays a critical role in facilitating *appropriate, high-quality* treatment. A diagnosis both justifies and facilitates research into new treatments. As these treatments are developed and determined to be effective, they can be applied to other individuals with the same disorder. Eventually, this research base allows for practice guidelines that ensure the wider dissemination of effective treatments. For example, defining PTSD as a disorder that can exist across both combat and non-combat trauma has facilitated the application of therapies that were

originally developed for rape victims to combat veterans (Foa, 1991).

Finally, classifying PTSD as a disorder has facilitated the receipt of benefits designed to offset the financial impact of disabilities associated with the disorder. Across both the VA and Social Security Administration, disability benefits are often available with an appropriate diagnosis in conjunction with a demonstration of specific impairments related to the diagnosed disorder. For example, a PTSD diagnosis permits certain veterans to receive disability compensation from the VA. Section 38 4.130 of the Code of Federal Regulations designates codes for mental disorders, including PTSD, and outlines the formula for rating disability resulting from a mental disorder. The formula assigns scores of 0, 10, 30, 50, 70, or 100. A rating of 0 signifies that a mental disorder has been diagnosed but that symptoms do not interfere with social or occupational functioning. A rating of 100 signifies that an individual suffers from total social or occupational impairment (U.S. Government Printing Office, 2010).⁴ Depending on the rating, an individual may be eligible for cash benefits and greater access to VA health services.

The Broader Impacts of the PTSD Diagnosis

The diagnostic categories that have been crafted to meet the needs of the psychiatric profession are also used within a wide range of other organizations or institutions for their own purposes. Use of these diagnoses within organizations or institutions outside the psychiatric community may have implications for how society perceives or responds to disorders such as PTSD. In particular, such broad and varied use of a diagnosis may lead to legitimization of the condition, stigmatization of those with the condition, and discrimination against those with the condition. We address each of these topics below to explore the full range of implications of the PTSD diagnosis.

Legitimization of the Condition

A diagnostic classification generated by the medical profession can affect how society views those with the condition as well as how those with the condition view themselves. A diagnosis may result in increased recognition and acceptance of the underlying phenomenon by diagnosed or symptomatic individuals, as well as by society in general (Jutel, 2009). It may also render pain and suffering more visible and give sufferers the tools to explain what makes them different from “healthy” individuals (Parsons, 1951; Jutel, 2009). With this, sufferers are able to make socially “legitimate” illness claims and attain recognition of their suffering (Dumit, 2006; Jutel, 2009). Legitimization of a condition can lead to a wide range of social benefits—including, but not limited to, increased access to medical treatment. Legitimization may enable sufferers to avoid blame for their ailments (Jutel, 2009) and exempt them from their everyday roles in society (Freidson, 1970; Jutel, 2009). For example, it may alter others’ expectations of the diagnosed individual at work or in family life. For these reasons, the nonmedical characteristics of a

There is no known empirical evidence demonstrating that the proposed name change is perceived as beneficial among service members, would result in a more socially acceptable category, or would increase the number of those seeking treatment.

diagnosis—for example, the label itself and the perceptions that it engenders—may be of substantial concern to those diagnosed. When a condition is not formally recognized with a diagnostic classification, sufferers of that condition may engage in the process of scientific discovery or diagnostic formation (e.g., Crossley, 2006; Brown and Zavestoski, 2004; Brown, 1995) in an attempt to gain recognition for their suffering in a way that is acceptable and useful to them. To a certain extent, this is what occurred in the case of PTSD's incorporation in the DSM-III; as previously noted, Vietnam veterans, as well as individuals representing other traumatized groups, played a role in the process of diagnostic formation (Scott, 1990; Scott, 2004).

The 2012 proposal to change the PTSD diagnostic label was voiced by senior U.S. Army leadership, and a number of individuals both within the military and outside it appeared to be in favor of such a change (e.g., PTSInjury, 2012). However, there is no known empirical evidence demonstrating that the proposed name change is perceived as beneficial among service members, would result in a more socially acceptable category, or would increase the number of those seeking treatment. Although the *creation* of the PTSD diagnosis in 1980 is perceived by many to have legitimized the set of symptoms experienced by individuals with PTSD, there is no evidence that the specific *name change* proposed would generate a similar or broadened effect. Nor, to our knowledge, is there a unified collective statement or set of statements on the part of service members, veterans, or groups that advocate for them regarding the proposed change; formal positions appear to be limited and varied (e.g., PTSInjury, 2012; Vietnam Veterans of America, 2012).

To better inform discussion of the issue, the American Legion hosted a meeting in June 2012 addressing the implications of the proposed name change, with a report outlining the findings and recommendations released later in the year (American Legion, 2012). A coherent “voice” may eventually emerge among service members, veterans, or the groups that advocate for them. But at this point, if the APA is interested in revisiting the issue—or the military, service members, and veterans are interested in creating a label that frames the PTSD diagnosis in a way that is more socially legitimizing and increases treatment utilization—they should take steps to ensure that discussions

about the proposal are informed by more systematic input from representative samples of those military service members, veterans, and other traumatized or victimized individuals who would be directly affected by the change.

Stigmatization of Those with the Condition

While diagnosis is designed to reduce suffering, it can instead serve as a basis for blame and create a stigmatized social category (Jutel, 2011; Jutel and Nettleton, 2011). A stigma is the negative evaluation resulting from a social label (e.g., diagnosis) or attribute (Goffman, 1963; Jones, 1984; Link, Phelan, et al., 1999). To be stigmatized is to be devalued, dehumanized, or seen as flawed due to one’s attributes or group membership (Goffman, 1963; Crocker, Major, et al., 1998). It is plausible that concerns about, or fear of, PTSD-related social stigmatization inhibit treatment-seeking or treatment-adherence for PTSD (U.S. Department of Health and Human Services, 1999). In fact, there is a great deal of evidence to support the existence of mental illness stigmatization in general. However, there is little empirical evidence documenting the nature of PTSD-related stigmatization specifically or demonstrating negative effects of PTSD-related stigmatization on treatment utilization.

Research shows that, in general, people dislike or desire social distance from (i.e., stigmatize), those with mental illness. For example, negative representations of the mentally ill have been shown to be quite common in the media (Signorielli, 1989; Wahl, 1995). Some individuals consider mental illness to be a socially undesirable label, on par with drug addiction or ex-convict status (Albrecht, Walker, et al. 1982). Those suffering from a mental illness are regularly seen as dangerous or too incompetent to handle their own affairs (Link, Phelan, et al., 1999; Pescosolido, Monahan, et al., 1999).

Few studies (Pietrzak, Southwick, et al., 2009) specifically demonstrate stigmatization among U.S. military service members with PTSD. Moreover, it is difficult to assess the extent to which research demonstrating the existence of mental illness stigmatization generally can be applied to PTSD-related stigmatization specifically (or to stigmatization associated with major depressive disorder, which is highly comorbid with PTSD). The reason is that not much is known about how people interpret the term “mental illness.” Some researchers assert that the term “mentally ill” is commonly applied to those with nonpsychotic illnesses (Phelan, Link, et al., 2000), while others argue that the term is more synonymous with the labels “insane” or “psychotic” (Thoits, 1985), which do not describe individuals with PTSD. Others have suggested that mental health *treatment*, regardless of the underlying diagnosis, may result in negative views of the individuals receiving it (Link, Phelan, et al., 1999). Based on this literature, it is unclear whether the available claims about the stigmas of mental illness can be extended to PTSD-related stigmas.

Similarly, there are no known studies showing that PTSD-related social stigmatization reduces the utilization of treatment. Some research exists on the relationship between treatment

utilization and stigmatization associated with major depressive disorder, an illness that shares some symptoms with PTSD, but the effects documented in the research are not consistent. For example, stigmatization concerns have been shown to have a negative effect on treatment utilization by depressed individuals living in rural areas, but the effect is not present for depressed individuals living in urban areas (Hoyt, Conger, et al., 1987; Rost, Smith, et al., 1993). In addition, stigmatization concerns have been found to be associated with treatment discontinuation among depressed older adults but not among depressed younger adults (Sirey, Bruce, et al., 2001). While these studies indicate that fear of stigmatization may serve as a barrier to treatment for depression, the effects that have been found to date apply only to certain populations or settings. Hence, it is possible that the characteristics of various military populations and the contexts in which they seek treatment affect whether and how PTSD-related social stigmatization affects the utilization of treatment.

Inconsistencies in the evidence of stigmatization as a barrier to care may be due to a complex relationship between stigmatization and treatment seeking. For instance, one might argue that concerns about being stigmatized could motivate a sufferer to seek treatment. Thoits (1985) implies that in some situations an individual may be highly motivated to eliminate symptoms of a psychiatric disorder to avoid stigmatization. In such situations, the stigmatization might encourage individuals to seek treatment as a means of eliminating the symptoms and behaviors associated with the diagnosis. The treatment-motivating effect of stigmatization can be seen with other types of medical diagnoses such as sexually transmitted diseases, which are often more stigmatizing than mental illnesses (see Westbrook, Legge, et al., 1993).

Given the inconclusive nature of the existing evidence, further research may be needed to more accurately predict the effect of PTSD-related stigmatization on treatment utilization. In particular, we may need a better understanding of the root cause of PTSD-related stigmatization. If it is related to the specific pattern of *symptoms or behavior* typical of PTSD, then fear of stigmatization may motivate individuals to seek treatment as a means of eliminating the symptoms or behaviors. If it is related to the *diagnostic label*—be it the term “disorder” or the existence of a psychiatric diagnostic label more generally—then fear of stigmatization may cause individuals to eschew treatment providers in order to avoid the diagnosis. If it is related to the *mental health treatment*, then fear of stigmatization would reduce treatment utilization regardless of the name given to the disorder. In the absence of research addressing these competing hypotheses, it is not known whether the existing label results in a stigma that reduces treatment utilization.

Discrimination Against Those with the Condition

While psychiatric diagnoses are designed to meet the needs of the mental health treatment, research, and educational communities, they are often used within other organizations or institutions for purposes beyond their designed intent. Discrimination

is one such practice (Jutel, 2011; Jutel and Nettleton, 2011). For example, a PTSD diagnosis may be used against an individual in court to suggest that he or she should not be given custody of a child, despite the fact that the diagnosis itself does not require any assessment of parenting skills or competencies. Similarly, the diagnosis may be used by an employer to select workers or to determine work assignments and promotions even though the diagnosis does not require any assessment of task competencies or reliability. While some social, occupational, or other type of impairment is a necessary diagnostic criterion of PTSD, the disorder manifests differently in each individual; the mere presence of a diagnosis provides no reliable information about how broad or narrow the impairment may be. It is worth noting that, as with other forms of institutional discrimination (Merton, 1970; Feagin and Feagin, 1978), PTSD-related discrimination within organizations or institutions may exist regardless of the attitudes or intentions of individuals within those institutions and so, too, regardless of social stigmatization. Discriminatory practices and procedures may become ingrained in the fabric of an organization or institution. Therefore, PTSD-related discrimination may persist even if individuals with PTSD were generally admired or seen as heroic.

The U.S. military—and in some cases, the government more broadly—uses information about psychiatric diagnoses, such as PTSD, or mental health treatment for purposes that may adversely affect how a diagnosed individual is treated. For instance, the DSM definition of PTSD is routinely used to aid government efforts to assess potential security risks or trustworthiness, despite the fact that the diagnosis does not require any assessment of those characteristics. Individuals are required to report mental health treatment and diagnoses as part of the process for determining eligibility for security clearances,⁵ and because security clearances are a requirement for many military occupations and some postmilitary careers, service members may forgo treatment to avoid any potential harm to their military or postmilitary careers.

The U.S. military also uses information about psychiatric diagnoses and mental health treatment as part of its evaluation of personnel, in particular to determine whether service members are fit for deployment. Information about diagnoses and treatment is made available to commanders to aid in their management of personnel and units. However, the inferences that commanders draw from this information may not correspond to the assessment that led to the diagnosis or may be based on an inaccurate understanding of the disorder. For instance, the DSM criteria for PTSD do not require any assessment of an individual’s ability to carry out his or her military occupation, nor do the criteria address how the individual would respond to deployment. The PTSD diagnosis does entail some functional impairment, but for some individuals, the impairment may be limited to non-occupational situations, such as intimate relationships. Indeed, it has long been recognized that many PTSD symptoms are both normal and functional when the individual is engaged in a dan-

gerous or stressful activity (Cannon, 1932; Hoge, 2010). Some researchers have speculated that soldiers with PTSD perform better than average during combat (Hoge, 2010).

Service members who are deemed not deployable and placed on restricted or modified duties can face significant, negative career impacts. These individuals are separated from their units during deployment and, as a consequence, might not receive the substantial financial benefits provided to those who deploy. They might not be eligible for the types of responsibilities or experiences that lead to promotion. Moreover, their absence could inconvenience or irritate others in their units, which could damage personal relationships or negatively affect their personnel evaluations. Although PTSD diagnosis or treatment does not automatically disqualify a service member for deployment, the information is routinely shared outside the mental health treatment team for use in evaluating personnel. Hence, a PTSD diagnosis could have a negative impact on an individual's career trajectory, even if the individual is deemed qualified to deploy.

While these forms of discrimination are prohibited by law in civilian environments, military service members are not protected by these same laws. The Americans with Disabilities Act and the Rehabilitation Act, for example, require public and private businesses to make certain accommodations for those with disabilities; however, the Disabilities Act does not apply to DoD, and the Rehabilitation Act applies only to DoD civilians and not to uniformed military service members. The Health Insurance Portability and Accountability Act, which protects the privacy of individually identifiable physical and mental health information, contains military exemptions. These exemptions permit the release of health information to commanders for certain purposes, such as determining whether a given service member is fit to perform his or her military duties.

Data support the claim that fear of discrimination is a significant barrier to the seeking of treatment by U.S. military service members. In its 2008 *Invisible Wounds of War* study, RAND surveyed military service members about factors that might prevent them from seeking mental health treatment if it were needed (Schell and Marshall, 2008). Barriers related to discrimination in the workplace were among the most highly cited: 44 percent of respondents thought they might not get help because it would harm their careers. In contrast, social stigmatization concerns were not as highly endorsed; only 12 percent of respondents suggested they would not get treatment because their friends or family would respect them less.

The Proposed Change to the PTSD Label

In late 2011, U.S. Army leadership requested that the APA drop the term "disorder" from the PTSD diagnostic label in its new edition of the DSM, the DSM-5. The proponents' rationale for using this new term was that it is less stigmatizing and would encourage more U.S. military service members suffering from symptoms to access care. The APA considered adding a diagnostic subcategory of PTSD, such as "*combat posttraumatic injury*." It also discussed

changing the name of the diagnosis to "posttraumatic stress *injury*" and there is some indication that the latter option may have been preferred at the time of the initial request (Jaffe, 2012; Oldham, 2012). The option of simply removing the word "disorder" was not considered by the APA. Ultimately, the APA decided to retain the word "disorder," (the "D") in PTSD. It is unclear whether the debate over the diagnostic terminology will continue in the months or years following the publication of the DSM-5.

Despite the APA's decision to retain the "D" in "PTSD," the proposal raised questions about whether the term "injury" is preferable to "disorder." Proponents of the change have argued that "injury" is the preferred term because it would lead to an increase in treatment utilization by reducing the stigma associated with the diagnostic label. However, there is no known empirical evidence indicating that a psychiatric "injury" generates less stigmatization than a psychiatric "disorder." In fact, it may be the case that the public views psychiatric "injury" as more permanent, more severe, or more disabling than psychiatric "disorder." Without the requisite empirical evidence, it likely would have been premature for the APA to replace the term "disorder" with "injury" in order to reduce stigmatization.

Adopting the term "injury" also could have implications beyond the effect on the likelihood of stigmatization. There is no known empirical evidence pertaining to the use of the term "injury" in "PTSI," thus making it unclear exactly what these implications may be. However, it is conceivable that a new label could be misleading to patients and clinicians in several ways. First, the term "injury," as it is commonly used and as it is defined by WHO, refers to physical (rather than psychological or emotional) harm or impairment inflicted upon an individual. Thus, the term "posttraumatic stress *injury*" may suggest that the disorder happens to the individual, when in fact the disorder is the individual's response to a traumatic event. It is unclear how individuals suffering from PTSD might perceive their ability to seek or continue treatment if they view themselves as *victims* of an injury.

Second, it is unclear how populations that are not physically engaged in frontline combat (e.g., pilots of remotely piloted aircraft, care providers, and chaplains) might perceive the term "injury" and how that perception might affect their willingness to seek treatment if they experience PTSD symptoms. It is possible that the term "injury" would lead to the mistaken impression that an individual would need to have been *in a position to be physically harmed* in order to obtain the diagnosis and be eligible for treatment.

Third, it is unclear whether the term "injury," which usually signifies an *instance* of being injured,⁶ is an appropriate term to describe a phenomenon defined by one's current level of functionally impairing symptoms rather than a discrete event in the past. Individuals with delayed-onset symptoms may be misled by an "injury" diagnosis because their symptoms do not coincide temporally with an incident they recognize as an injury.

Alternatively, those whose PTSD symptoms persist continuously from the time of a traumatic event may mistakenly perceive

that the basis for the disorder lies in the past rather than in a current cognitive and emotional state. In fact, symptoms may be adaptive at one time (e.g., in the face of trauma) and functionally impairing at another time (e.g., upon return from deployment). In short, labeling PTSD as an injury may give the erroneous impression that the disorder is determined entirely by discrete events in the past, thereby understating the role of one's current cognitions, emotions, and environment in maintaining the disorder. Such a misperception might, in theory, make the disorder appear less treatable.

Moreover, we note that (a) no empirical evidence exists to support a link between adopting the term "injury" and a reduction in stigmatization, and (b) the discriminatory practices linked to the PTSD label could be easily transferred to the new label. Hence, we believe that altering the label or acronym—without making more wholesale changes to how the disorder is defined, how diagnosed individuals are treated, or how the military uses information about diagnosis and treatment—is unlikely to generate dramatic changes in treatment-seeking or treatment-utilization. Further, there exists a body of work on the barriers to psychiatric treatment (see Parcsepe and Cabassa, 2012; Vogt, 2011), and implementing strategies informed by this evidence may be more productive than changing the PTSD label.

It is also worth noting that while the U.S. military has requested that the APA change the diagnostic label from "disorder" to "injury," the military does not currently treat PTSD as it does other combat injuries. PTSD is not sufficient to earn a Purple Heart, an honorable decoration awarded to service members who have been wounded or killed in action. Only service members who have suffered enemy-inflicted physical injuries (e.g., those caused by enemy fire or explosive devices) are entitled to receive the award. If the APA decides to change the term "disorder" to "injury" but the U.S. military continues to omit PTSD from the category of combat injuries that qualify for a Purple Heart, the new label's intended effect of reducing stigmatization may be undermined. There is some precedent for awarding decorations such as the Purple Heart to service members with PTSD: Canada's military awards the Sacrifice Medal, an equivalent to the Purple Heart, to those with mental disorders (or operational stress injuries) attributed to hostile action (National Defence and the Canadian Forces, 2012).

The Informal Use of "PTS"

Military leaders and others have informally used the term "post-traumatic stress" or "PTS" to refer to PTSD as well as stress responses that do not meet the clinical criteria for a mental disorder. For example, the U.S. Army has begun using the term in place of "PTSD" on certain documents and websites and in some statements and presentations by senior leaders. The rationale echoes the impetus behind the desired diagnostic label change—the term "PTS" is thought by some to be less stigmatizing than "PTSD" and expected to encourage more U.S. military service members suffering from symptoms to access care. Given the APA's recent

decision not to change the PTSD diagnostic terminology, it is unclear whether and to what extent use of the term "PTS" will continue, and what the full range of its effects may be.

The term "PTS" may be misleading to service members or the general public if used in common lexicon in lieu of or alongside formal diagnostic terminology. This may be especially true if "PTS" is used to refer to chronic and clinically significant reactions. Although "PTS" may be appropriately applied to post-traumatic stress responses that *do not* meet the clinical criteria for PTSD—for example, transient reactions lasting a matter of hours or days—referring to disordered reactions as "stress" obfuscates one of the defining features of PTSD. The disorder is characterized not by the presence of stress itself but rather by the failure to spontaneously recover from stress in a normal manner. The pattern of symptoms associated with PTSD may be perfectly normal and healthy during exposure to a stressful situation. PTSD is a disorder only to the extent that it persists long after the actual stress is removed. Labeling a problematic set of symptoms with "PTS" fails to convey this distinction between a normal stress response and a problematic one (which persists and is functionally impairing).

Even if "PTS" is used to refer to transient or subclinical stress responses, the term could still be misleading to members of the military or the general public. For example, service members experiencing PTSD symptoms could, in theory, assume that these symptoms are characteristic of a less severe "PTS" and therefore not feel that treatment is warranted or would be beneficial. In other words, labeling subclinical stress responses could normalize these responses and convey the message that they should not or will not become problematic. This may be especially true if messages about a normal and transient "PTS" within military communities were to become highly prevalent and overshadow messages emphasizing the importance of or channels for seeking mental health treatment. Moreover, the U.S. military already utilizes its own specific terminology, "combat and operational stress reaction," (COSR) to refer to combat-specific reactions that do not meet the clinical criteria for PTSD or other mental disorders (Brusher, 2011). In addition, some COSR and/or "PTS" cases could meet the clinical criteria for ASD. It is not known whether the existence of these multiple and potentially overlapping labels—that is, PTS, COSR, and ASD—may further complicate service member or general public understandings of combat-related stress. Nor is it known whether the coexistence

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of these labels could affect the likelihood that service members suffering from symptoms would seek treatment.

Further, the use of an additional term such as “PTS” to label PTSD or PTSD-like symptoms may create challenges for the military disability system and the Veterans Health Administration, as well as service members and veterans accessing benefits through these systems. The widespread use of this label may make it more difficult to claim disability benefits for those service members who could be accurately labeled with a disability-eligible code from the DSM or ICD-10 taxonomy, but are instead labeled with “PTS.” Currently, the term “PTS” does not confer eligibility for disability benefits or medical retirement. Therefore, individuals labeled with “PTS” who also meet the criteria for a psychiatric disorder such as PTSD may require multiple labels to access the appropriate range of benefits, services, or accommodations. The use of nonstandard terminology may also result in confusion among mental health care providers or lapses in care. For example, as individuals transition from the military health system to the VHA or civilian environments, providers in these settings may not be aware of the term “PTS,” its specific meaning or clinical implications, and the standards for its care. Although many of these problems could be avoided if “PTS” were used *only* to refer to transient or subclinical responses, current use of the term does not appear to be limited to these instances. Moreover, the benefit of such usage is unclear, particularly given its possible overlap with the current COSR and ASD labels.

Proponents of the term “PTS” assert that this label is useful because it would lead to an increase in treatment utilization by reducing the stigma associated with the term “disorder.” However, as with the term “injury,” no known empirical evidence documents stigmatization specifically related to the term “disorder,” particularly among individuals with PTSD. Nor does evidence demonstrate negative effects of PTSD-related stigmatization on treatment utilization. To the extent that such a stigmatization could exist (and not be documented), this stigma could be easily transferred to the “PTS” label. So, too, could the discriminatory practices linked to the PTSD label. Further complicating the effects of any changes in PTSD terminology is the widespread adoption of the acronym by the U.S. military and the general public. The acronym is used as a stand-alone word without reference to the underlying terms denoted by each letter. It is not known how many people associate the term “disorder” with the PTSD label, nor whether replacing the term PTSD with “PTS” would induce a noticeable change in the way society perceives the underlying problems.

It is worth noting that the Canadian military, like the U.S. military, uses its own terminology to refer to certain mental health issues. The term “operational stress injury” describes any of a number of ongoing clinically significant psychological difficulties resulting from military service (Veterans Affairs Canada, 2012a). The term was created in response to concerns about mental illness stigma similar to those found among U.S. military service members, and includes PTSD as well as other mental health ailments, such as anxiety and depression. The term “opera-

tional stress injury” refers to clinical disorders as well as other, less-severe conditions that still interfere with daily functioning (Veterans Affairs Canada, 2012).

Concluding Thoughts

Problems stemming from exposure to traumatic events have been characterized by numerous labels and subject to varying degrees of recognition over time. It was not until 1980 that PTSD was incorporated into the DSM, in part as a result of advocacy by and collaboration among psychiatrists and individuals representing traumatized groups. The creation of a PTSD diagnostic category was seen by many veterans’ advocacy groups as a major victory. The diagnosis encourages treatment utilization, research into treatments, and the development of practice guidelines to improve the effectiveness of treatment. It also legitimizes suffering and enables service members suffering from PTSD to receive VA disability compensation.

To ensure that these gains are maintained and that the diagnostic category remains useful, any changes to the PTSD label or endorsement of using new terminology should be supported by evidence that reflects the perspectives of the mental health treatment and research communities as well as the perspectives of military service members, veterans, and other traumatized individuals who would be directly affected by the change in terminology.

Currently, there is no evidence that PTSD-related social stigmatization has a strong or consistent association with treatment seeking. It is possible that making the symptoms less stigmatizing would reduce, rather than increase, treatment utilization. In addition, there is no formal evidence that the term “injury” generates less stigmatization than the term “disorder” does, and it is possible the term “injury” may come with its own set of unintended, negative consequences. Moreover, informal use of the term “PTS,” particularly when applied to clinically significant stress responses, may obfuscate the distinction between normal stress responses and problematic ones, and may therefore engender its own set of negative consequences.

More generally, the manner in which institutions use the diagnosis, rather than the specific label, is an important determinant of how service members view the disorder and how likely they are to seek treatment. Using information about psychiatric diagnoses or mental health treatment in ways that may adversely affect how the diagnosed individual is treated is likely to undermine efforts to reduce stigmatization and increase treatment utilization, regardless of the label used to describe the disorder. If information about the diagnosis and treatment of “PTSI” is made available to commanders for use in conducting personnel evaluations or managing military units, as it has been for PTSD, then the new label will also be seen as a direct threat to one’s military career. Use of the term “PTS” may persist, and the APA may eventually change course and alter the name of the disorder, but without changes to broader institutional factors, a name change at any level is unlikely to generate a significant increase in individuals willing to be diagnosed or treated.

Endnotes

¹We use the term *medical condition* or simply *condition* to refer to any set of physical or behavioral symptoms regardless of whether this set of symptoms is formally recognized by the medical profession. This differs slightly from other uses of the term. For example, the DSM-IV defines the term as “a convenient shorthand to refer to conditions and disorders that are listed outside the Mental and Behavioral Disorders chapter of the ICD,” or International Classification of Disease manual (APA, 2000).

²Versions 9 and 10 of the ICD manual are currently in use, and, as stated in the DSM-IV-TR, are both compatible with the DSM-IV-TR. Clinical modifications of the manual, known as the ICD-9-CM and ICD-10-CM, have been produced and adopted for coding morbidity data in the United States. In January 2009, the U.S. Department of Health and Human Services published a final rule mandating adoption of the latter version (Centers for Medicare and Medicaid Services, 2012). A compliance date of October 1, 2014, was set on April 17, 2012.

³To the authors’ knowledge, the state of the current literature is similar to the state in 1980. The scientific literature has not shown evidence that individuals who experience military combat trauma have a different symptom presentation or respond differently to treatments than civilian trauma victims.

⁴Regulation 38 §4.130.

⁵Recently, exceptions have been made with respect to combat-caused disorders.

⁶The WHO definition of an injury, which we use to guide our analysis (and provide earlier in this paper), states that an injury is “acute overexposure” to a physical force and presumes that this overexposure occurs in a certain place, while engaging in a certain activity, and via a specific mechanism. Therefore, while WHO definition does not explicitly state that an injury occurs at a given point in time, or during a given instance, we believe that this inference could be reasonably made. The inference is also consistent with common uses of the term.

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About This Report

This paper presents a synthesis of historical, sociological, and clinical literature on the diagnosis of psychiatric disorders, focusing on PTSD in particular. It is likely to be of interest to members of the APA's DSM-5 Task Force and decisionmakers within the Department of Defense and the Department of Veterans Affairs who are concerned with mental health issues and policies. This paper may also be useful to staff at organizations that advocate for service members and veterans on issues of mental health.

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